Maximizing Treatment Effectiveness in Clinical Practice: An Outcome-Informed, Collaborative Approach

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ABSTRACT

Clinicians need easy-to-use, practical, systematic methods of evaluating, informing, and reporting the effectiveness of treatment. Practicing clinicians no longer have to rely on the DSM for treating their clients, but by making use of both outcome and process measures they can create a more collaborative and effective therapy with their clients. The findings from over 40 years of psychotherapy outcome research literature emphasize the importance of common factors as the curative elements central to all forms of therapy regardless of theoretical orientation. Methods discussed here offer practitioners the means to identify which clients are responding to treatment and those for which treatment is not working so that adjustments can be made to the therapy. The goal is to decrease dropout rates, increase levels of customer satisfaction, and document and improve the overall effectiveness of treatment.

> We were knee deep in the Big Muddy,
> and the damn fool kept yelling to push on. — Pete Seeger

"Diagnosing mental illness is a difficult undertaking: what appears to be depression to one therapist just might be diagnosed by another as schizophrenia, manic depression, or just ordinary grief," observed Michael Horgan in his book, *The Undiscovered Mind* (1999, p. 79). Horgan goes on to state that "therapists often disagree over how a given disorder should be defined and even over what should be considered a disorder" (p. 79).

In an attempt to bring clarity and uniformity to the issue of diagnosis, the American Psychiatric Association developed and first published, *the Diagnostic and Statistical Manual of Mental Disorders*, commonly known as the *DSM*, in 1952.

Since its initial publication, there have been numerous revisions—in 1968, 1980, 1987, 1994, and the latest, the *DSM–IV–TR*, in 2000. The *DSM* is generated by teams of psychiatrists and is supposed to represent the consensus of the profession. However, if anything, it has only served to highlight the subjective nature of psychiatric diagnosis. Authors Herb Kutchins and Kirk Stuart in their 1998 book, *Making Us Crazy,* point out that

> the notion of a mental disorder is what social scientists call a construct. Now constructs are abstract concepts of something that is not real in the same physical sense say, as a car or a tree, in that these objects can be seen and touched. Constructs are shared ideas, supported by general agreement. For example, ideas

> like democracy, conservatism, and liberalism are constructs that have some degree of shared meaning within certain groups. Mental illness is also a construct, a shared idea, as are specific diagnostic categories in the DSM like generalized anxiety disorder. (p. 23)

The point here is that these constructs are held together solely by agreement, and these agreements change over time.

These same authors point out that the number of official disorders has grown from 106 in the *DSM–III* to more than 300 in the *DSM–IV*. They conclude that the *DSM–IV* reflects "the growing tendency in our society to medicalize problems that are not medical, to find psychopathology where there is only pathos, to pretend to understand phenomena by merely giving them a label and a code number" (p. x). In spite of these and other problems, the *DSM* has come to be regarded as the de facto standard for categorizing and understanding mental disorders.

"One would think that a profession devoted to mental health and mental illness for nearly a century and a half would possess some clear ideas about what constitutes mental illness and health," states Robert Fancher in *Cultures of Healing* (1995, p. 22).

However, as noted above, this doesn't seem to be the case. In order for a diagnosis to be useful, there must be a high degree of agreement among practitioners about its' accuracy. This is known as *reliability*. According to at least one major research study carried out in the early 1990's, mental health diagnoses are remarkably unreliable. For example, consider the study conducted by Williams and others (1992) of the *DSM–III*. In this large-scale, multi-site study, clinicians were extensively trained to make accurate diagnoses using the *DSM–III–R*. Following this elaborate training and supervision by the researchers, pairs of clinicians interviewed 600 patients to see if they could agree on a diagnosis, (agreement was defined as a diagnoses that fell within the same general class of disorders, not the specific type). Findings from this study, summarized by Duncan, Miller, and Sparks in the revised edition of *The Heroic Client* (2004) showed that

> overall agreement for these specially trained clinicians ranged from 68% to 72% for Axis I, and 56% to 64% for Axis II. Individual reliability ratings on specific disorders were as low as 26%. Because of the manner in which these field trials were set up, it was possible for one clinician to diagnosis an individual with dysthymic disorder and panic disorder, while a second clinician might diagnosis the same patient with major depressive disorder and obsessive-compulsive disorder. Both diagnoses would still be considered in agreement because they fall within the same general class of disorders. (p. 24)

A second major problem with the *DSM*, according to Duncan and Miller (2000), is the issue of validity. Validity addresses the question, "How useful is diagnosis to treatment?" For example, in the current version of the *DSM* there are nine separate and distinct criteria used for identifying borderline personality disorder (BPD). In order to qualify for a diagnosis of BPD, a patient only needs to be seen as exhibiting any five or more of the nine symptoms, which means that there are some 151 possible combinations of criteria to arrive at a diagnosis of borderline personality disorder. With so many possible combinations of arriving at the same diagnosis, how specific and useful can it be?

The *DSM*, with its current emphasis on the standardization of diagnosis and treatment, focuses primarily on the competence of service delivery, rather than the effectiveness of the services delivered.

Duncan and Miller (2000) point out that, "If the diagnosis of depression, for example were truly analogous to a diagnosis of diabetes for example, then it would allow the therapist to select the proper treatment for that specific disorder" (p. 48). These authors further point out that diagnosis does not select a remedy for individuals, nor does it predict how well they will succeed in treatment.

Enter the "Dodo Bird"

An overwhelming obstacle in this regard for therapists is that there has been no therapeutic approach that has demonstrated its superiority over another for any disorder. They all work similarly (Luborsky, Singer, & Luborsky, 1975; Bergin & Lambert, 1978; Meltzoff & Kornreich, 1970; Shapiro & Shapiro, 1982; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Lambert, Shapiro, & Bergin 1986; Lambert & Bergin, 1994). It was this finding that prompted Luborsky and others (1975) to borrow the now-famous "dodo bird verdict" from *Alice in Wonderland* and declare that "Everyone has won and all must have prizes" (p. 56). They said, "if a diagnosis fails to accurately identify a disorder and prescribe a particular treatment and is not linked to a person's success or failure with a given treatment of what possible value can it be to frontline clinicians?" Duncan, Miller, & Sparks (2004, p. 26).

These findings also appear to be true when comparing the use of psychotropic medications with various psychological interventions. This was demonstrated in one of the most extensive research studies conducted on the treatment of depression to date: the National Institutes of Mental Health Treatment of Depression Collaborative Research Program (TDCRP) (Elkin et al., 1989). In what is generally considered to be the most ambitious and methodologically sophisticated outcome study ever conducted, four different treatment protocols were compared for their effectiveness in the treatment of depression. The four approaches compared were Aaron Beck's cognitive therapy, interpersonal therapy as practiced by Gerald Klerman and Myrna Weissman, antidepressant medication, and placebo. In their summary of the findings from this study, Duncan

and Miller (2000) note "that given the sophistication of the study and the effort that went into designing it, investigators were surprised by their results" (p. 48). They noted that when all was said and done, the following were shown:

- There were no differences in overall effectiveness between the different treatment conditions.
- No winner had emerged from the data for the treatment of depression or any other disorder.
- Diagnoses do not help in treatment planning or selection.
- [Further] diagnosis does not inform the therapist in any meaningful way about what to do [in treatment]. (p. 48)

What is one to make of these findings, which tend to confirm that the theories psychotherapists' hold do not seem to have any relationship to therapy outcomes? Rather, positive outcomes seem to be due to other, "common factors."

On the one hand, it has been quite clearly demonstrated that the process of psychotherapy is a powerful, effective, and valuable tool, which is of significant benefit to those suffering from emotional distress. For example, it has been shown that psychotherapy is roughly four times as effective as no treatment and twice as effective as placebo (Hansen, Lambert, & Forman, 2002).

At a 2002 conference on data regarding psychotherapy outcome, researcher Michael J. Lambert pointed out that 40% to 60% of clients seen met criteria for clinically significant change following 12–15 sessions of treatment in clinical trials. He went on to note that 10–20% met these criteria in routine practice following 3–6 sessions. In addition, Lambert reported that about 50% of clients meet criteria for recovery after 13–20 sessions.

> The client is the single most potent contributor to successful outcome in counseling/therapy …

It has been reported elsewhere that "60–65% of clients experience significant relief within one to seven visits" (Miller & Duncan, 2000, p. 92). Earlier studies support this finding and indicate that the majority of client change that occurs in therapy happens earlier rather than later in the treatment process (Howard, Kopte, Krause, & Orlinsky, 1986). Early improvement, specifically, the client's own experience of meaningful change in the first few visits, is emerging as one of the best predictors of eventual outcome (Garfield, 1994).

In a major study conducted by Brown, Dreis, and Nace (1999) involving more than 2000 therapists and thousands of clients, it was found that therapeutic relationships in which no improvement occurred by the third visit did not on average result in improvement over the entire course of treatment. The same study also showed that clients who worsened by the third visit were twice as likely to drop out of treatment than those reporting progress.

In orally summarizing the findings from several meta-analytic studies in 2002, Lambert points out that those who are most disturbed change more and faster, but are not likely to finish in the normal range on most outcome measures. He further stated that providers of psychotherapeutic services can be confident that they have an overall positive effect on client functioning, and psychotherapeutic treatments are efficient and lead to lasting change in a variety of important areas.

If no significant difference in effect can be demonstrated by any one model of treatment, then how do we account for the improvements observed in clients?

Enter the Common Factors

Hubble, Duncan, and Miller, writing in *The Heart and Soul of Change* (1999), point out that the idea of common factors is not a new one. The possibility that various models of therapy have more in common than less was first broached about 70 years ago by Saul Rosenzweig. Writing in the *American Journal of Orthopsychiatry* in 1936, Rosenzweig suggested that "the effectiveness of different therapy approaches had more to do with their common elements than with the theoretical tenets on which they were based" (p. 412). Hubble, Duncan, and Miller write that if Rosenzweig wrote the first note of the call for common factors, then Jerome Frank composed an entire symphony. In all three editions of *Persuasion and Healing: A Comparative Study of Psychotherapy* (1961, 1973; Frank & Frank, 1991), Frank placed therapy within a larger family of projects designed to bring about healing. The authors noted that Frank identified four features shared by all effective therapies: (a) "an emotionally charged, confiding relationship with a helping person," (b) "a healing setting," (c) "a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them," and (d) "a ritual or procedure that requires the active participation of both patient and therapist and that is believed by both to be the means of restoring the patient's health" (p. 7).

However, it wasn't until 1992, when Michael Lambert proposed his model of the common factors in the *Handbook of Psychotherapy Integration* that the common factors model began to gain wider recognition and acceptance. According to Lambert, four factors are the essential elements responsi-

ble for the improvement observed in clients. Lambert further stated that the four factors appear to be common or central to all forms of successful therapy, regardless of theoretical orientation. He noted "that the research base for this interpretation was extensive, spanned decades, dealt with a large number of adult disorders and a variety of research designs" (p. 96). Miller, Duncan, & Hubble, writing in their 1997 text, *Escape from Babel,* provide the following overview of the common factors (pp. 25–31):

Extratherapeutic factors. "The research literature makes it clear that the client is the single most potent contributor to successful outcome in psychotherapy contributing as much as 40% to the improvement that occurs through treatment.… In fact, the total matrix of who they are, their strengths and resources, the duration of their complaints, their social supports, the circumstances in which they live, and the fortuitous events that weave in and out of their lives matters more than anything the therapist might do."

Relationship factors. It is estimated that as much as 30% of the variance in successful treatment is due to these factors, making them second only to extra-therapeutic factors in their contribution to successful outcomes. Studies further show that the quality of the client's participation in the therapeutic relationship is the single most important determinant of outcome (Orlinsky, Grawe, & Park, 1994). Clients, who are motivated, engaged, and who join in the work with the therapist benefit the most from the experience.

Expectancy, hope, and placebo. "Hope is strongly influenced by the therapist's attitude toward the client during the initial moments of counseling. Pessimistic attitudes conveyed to the client through an overemphasis on psychopathology or the difficult nature of change is likely to negatively impact the outcome of treatment." This factor contributes an estimated 15% of the variance in successful treatment.

Therapeutic theory and technique. "The data indicate that the therapeutic model and/or technique contribute only about 15% to successful outcomes. This means that in spite of the "profession's" investment in technical and theoretical factors, their actual contribution to successful outcomes pales in comparison to extratherapeutic and relationship factors."

Further support for the preeminent role of the common factors in successful psychotherapy outcomes can be found in the 2004 edition of *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (Lambert & Ogles, pp. 139–193). After their review of the data on the efficacy and effectiveness of psychotherapy, researchers Lambert and Ogles conclude that "based on a review of the evidence, it appears that what can be firmly stated is that factors common across treatments are accounting for a substantial amount of the improvement found in psychotherapy patients" (p. 172).

Becoming Outcome Informed

You might wonder how the field of psychotherapy—that for so long has been intent on identifying and diagnosing "mental illness," as well as its methods of treatment—would react to a shift from emphasizing the process of therapy to one favoring the measurement of outcome.

Actually, a tradition of using outcome measures to inform the process of treatment has been steadily emerging over recent decades. Duncan, Miller, and Sparks (2004) point out that "a growing body of outcome research indicates that the general trajectory of change in successful therapy is highly predictable, with most change occurring earlier rather than later in the treatment process" (p. 83).

It should be noted that the concern regarding outcomes in psychotherapy is a well- founded one. A 2002 study conducted by Hansen, Lambert, and Forman of over 6,000 clients in six different outpatient settings found that, on average, only 35% of patients improved or recovered.

Given the preceding data, the importance of providing practicing clinicians with a time- saving, practical, and systematic method for evaluating, informing, and reporting the effectiveness of their treatment, that is both reliable and valid cannot be overstated.

In this respect, it is important to note that those responsible for funding psychotherapy services, whether health maintenance organizations (HMO's) or public funding sources like Medicaid, have been quite uncomfortable with the lack of precision with which mental health services have traditionally been measured. At the same time, these third-party payers have become increasingly cost conscious while insisting that therapists be able to substantiate the effectiveness of their treatment in order to be reimbursed for their services.

To remedy this situation, therapists of all persuasions are being forced to develop an emphasis on concrete, specific outcome measures. In *Psychotherapy in the Age of Accountability* (1995), psychologist Lynn Johnson states that "an accountable therapist must be aware of current research and be a sophisticated consumer of that information" (p. 23).

> In the battle with cost-cutters and corporate naysayers, the routine, systematic assessment and utilization of outcome information are shaping up as the single best weapons that average practitioners have for both insuring the continuation of services and proving the value of their work. (Miller, Duncan, Johnson, & Hubble, 2000, p. 8)

In this regard, researchers Howard, Moras, Brill, Martinovich, and Lutz (1996) introduced a new paradigm

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for evaluating the effectiveness of psychotherapy. This new paradigm, known as *patient-focused research*, is concerned with monitoring an individual client's progress over the course of treatment and feeding back data on their progress or lack of progress to the clinician, supervisor, or case manager. Patient-focused research attempts to answer the question, "Is this treatment working with this patient, at this time, with this therapist?"

Lambert, Whipple, Hawkins, Vermeersch, Nielsen, & Smart (2003), in summarizing the results of a meta-analytic review of three large-scale studies employing this patient-focused approach, suggest "that formally monitoring patient progress has a significant impact on clients who show poor response to treatment, implementation of this feedback system reduced deterioration by 4% to 8% and increased positive outcomes" (p. 288–301).

> Reliable and valid means exist for evaluating progress and overall effectiveness in treatment. "Rather than repeating the failures of the past by attempting to determine a priori what approach works for which problem, these methods focus on how well a given treatment is working for an individual client at a specific point in time." (Miller, Duncan, Johnson, & Hubble, 2000, p. 12)

What to Measure?

The questions facing practicing clinicians are "What to measure?" and "How can I tell if clients are responding to treatment?" From the same article, Miller, Duncan, Johnson, & Hubble (2000) identify two bases of measurement that factor into any determination of successful outcome:

1. Clinical outcome measures, which assess the impact or result of the service a therapist offers their client
2. Customer satisfaction measures that assess the client's perception of how well they were served, including such factors as courtesy, timeliness, accessibility, professionalism, the strength of the therapeutic relationship, and qualities of the treatment environment (p. 14)

A growing body of research studies conducted over the past 20 years has found that a combination of the client's ratings of the therapeutic alliance as well as their experience of meaningful change in the initial stages of treatment are highly reliable predictors of eventual treatment outcome. The data indicates that "the general trajectory of change in successful therapy is highly predictable, with most change occurring earlier rather than later in the treatment process" (Miller, Duncan, & Hubble, (2004, p. 6). These same authors note that "more recently, researchers have been using early improvement—specifically, the *client's* subjective experience of meaningful change in the first few visits—to predict whether a given pairing of client and therapist or treatment system will result in a successful outcome" (p. 6). The work of researchers like (Haas et al., 2002; Garfield, 1994; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001) supports these findings while the work of researchers Howard, Lueger, Maling, & Martinovich (1993) not only confirms these findings, but also found that "the absence of early improvement in the *client's* subjective sense of well-being significantly decreased the chances of achieving symptomatic relief and healthier life functioning by the end of treatment" (p. 7). In addition, research conducted by Johnson (1995) and Johnson & Shaha (1996, 1997) documented the positive impact of outcome and process tools on the quality of psychotherapy outcomes.

Measures of clinical outcome tell the therapist how they are doing, while customer satisfaction measures provide feedback about what a therapist actually did to obtain a particular result.

A number of excellent resources exist for helping front-line clinicians to understand and select those outcome measures that are most appropriate to their practice and or agency environment. Two of the better volumes are *Assessing Outcome in Clinical Practice* by Ogles, Lambert, and Masters (1996) and *Measures for Clinical Practice* by Fischer and Corcoran, (1994).

Measures that incorporate both outcome and process data increase the likelihood of being able to identify when therapy is going well and when it is off track. The ability to detect when therapy is off track, earlier rather than later, allows the clinician to take corrective steps at an early stage to bring the treatment in line with the needs of the client.

This collaborative process (outcome-informed) invites consumers of therapy to become full and equal participants in the treatment process.

What's in it for me? Why should I want to become client-directed and outcome-informed?

In *Essentials of Outcome Assessment*, Ogles, Lambert, and Fields (2002) list the following reasons for conducting outcome assessments (p. 2):

- To improve treatment
- To enhance clinical science
- To provide accountability
- To maintain the ethical responsibility of practitioners to examine quality

In addition, organizations and agencies adopting an outcome-informed, client-directed approach to treatment can expect to benefit by their therapists' ability to generate actual proof of the effectiveness of their work. Over time, these agencies will be able to document any special abilities a particular clinician has for working effectively with special populations, thereby bringing about a more effective and efficient utilization of their human resources. Organizations and agencies adopting an outcome-informed, client-directed approach are able to identify which clients' are quick responders and those for which treatment is not working, so that adjustments can be made to the therapy, hopefully reducing dropout rates, and increasing levels of customer satisfaction with their services and overall success rates.

Client-directed, outcome-informed treatment also has the potential to simplify the interaction between mental health professionals and managed care, as well as other third-party payers. Many managed-care organizations continue to require that clinicians complete lengthy reports and treatment plans. Unfortunately, these reports often do not serve the consumer/client, nor do they accurately reflect what is going on in treatment.

These reports by their nature do little to improve the effectiveness of treatment. Worse yet, this process may not even help to control the cost of outpatient care, though they were designed for this purpose. In fact, there is evidence that the typical review process actually increases costs (Johnson & Shaha, 1997). In their research, the authors noted that every time a care manager contacts a therapist, it costs the managed care organization between $60 and $70.

In addition, the Institute of Medicine issued a landmark report in March of 2001, entitled *Crossing the Quality Chasm*, in which the committee responsible for the report specifically identified a shift toward client-directed service as a basic tenet for improving the quality of mental health care.

Unfortunately, existing outcome management systems can take up to 90 minutes to complete, resulting in low compliance on the part of both clients and clinicians. In an effort to resolve this problem, Duncan and Miller (2000) have developed the only outcome management system that currently tracks both outcome and process data. In contrast to other time-consuming systems, their system, which makes use of visual analog scales, takes only 2–3 minutes to complete. The brief time required to complete the instrument, as well as the simplicity of design, should greatly increase both therapist and client involvement in the outcome management process.

By utilizing standardized measures, the need for therapists to constantly send detailed reports containing sensitive and potentially damaging personal information would be eliminated. In addition, utilizing standardized measures that communicate both ongoing outcomes and process data can predict with a higher degree of certainty the value of the delivery of therapy and/or continuity of service.

Managed care and other third-party payers can finally have something other than cost alone to consider when authorizing treatment. By utilizing both outcome and process measures, they can have the hard data to see the effectiveness of the service provided for themselves (i.e., client change). They can also see the efficiency (i.e., the number of sessions it takes to achieve that change) and the customer satisfaction ratings of a particular therapist, agency, or provider group. These data can be used to rate individual therapists, agencies, or provider groups, and assist in issues like continuation and appropriate levels of client care.

Summary

To recap, serious questions were raised over whether or not the *DSM* can provide a valid and reliable means for clinicians to select a remedy for their patients' presenting problems as well as its ability to predict who will benefit from treatment. Secondly, research on the importance of the common factors were reviewed with regard to their importance to successful outcomes. Thirdly, an alternative method of monitoring treatment outcomes was suggested based on the new paradigm of patient-focused research.

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